3. Results

Whenever possible, data was analysed with parametric statistics. Since a lot of the data is qualitative in nature, non parametric statistics was mostly done.

Before we get to proof the several hypotheses, results about descriptive data (general information) will be shown in the same order as the questions arise during the interview.

3.1 Descriptive Data

In the section about methods the data referring to gender, age, profession, years of experience and whether working in an institution specialized for victims of organized crime was presented.

In Figure 2 we can appreciate the relation given by the therapists to the question if they would classify their therapy as symptom-relieving or a rather trauma-focused therapy. So subjects, who answered working a 100% trauma focused, answered with 0% to symptom-relieving; meaning that they did not handle current daily problems in their therapy. Subjects working on a 50% trauma focused basis automatically did 50% symptom-relieving work.

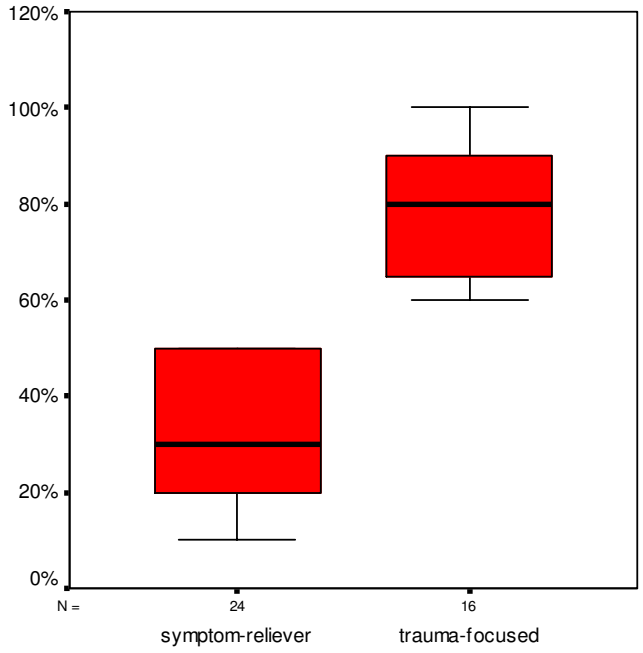

Figure 2: Distribution of symptom-relieving and trauma-focused therapists.

In this work, I may use “European group” to refer to participants from Switzerland and Germany.

The next question in the interview was about the theoretical approach(es) used during therapy, 67.5% (27) of the psychotherapists declared to use a cognitive-behavioural approach during their work, 14 (35%) even indicated to always use this approach. Psychoanalysis was disclosed to be used by 17 (42.5%) of the participants, rational-emotive therapy by 13 (32.5%), systemic therapy by 23 (57.5%), counselling by 20 (50%), pharmacotherapy by 15 (37.5%) and art therapy by 10 (25%) therapists. Other approaches mentioned were existentialist, eclectic, gestalt and EMDR (eye movement desensitization response) with 2 cases each (making a total of 20%); hypnotherapy was named in 3 cases (5%); body psychotherapy in 4 cases (10%); and logotherapy, gender-sensitive, neurolinguistic programming, rebirthing, and psychoeducation with one case each.

Not many (4) subjects plan up to five sessions for their traumatized patients. Fifteen (37.5%) psychotherapists plan between six and fifteen therapy sessions and 21 (52.5%) plan more than 15 therapy hours for a traumatized patient at the beginning of the treatment. Most institutions in Europe (mainly) plan more than 15 hours for their patients.

The mean number for the amount of traumatized persons treated in the last year was of 64 patients. The percentile 75 was by 50 patients. The rang was from 0 to 900 clients, but there is a big gap between 250 and 900. Needful to explain here is that the person who took care of 900 clients in a year only listens to their complaints and does not give therapy to even a quarter of them.

The mean of the current number of treated patients who specifically have lived a traumatic event is higher in Guatemala ($x= 29.55$, $SD= 51.439$) than in Germany and Switzerland ($x= 11.94$, $SD= 10.061$), but the difference is not significant. Figure 3 below illustrates this result after taking out the extreme points from the Guatemalan sample. The mean of the total number of patients treated at the time of the interview was of 22 patients in Europe and 36 in Guatemala, the median being 20 patients in both groups.

The number of current sessions per week for all psychotherapists was an average of 6, the median being 3.

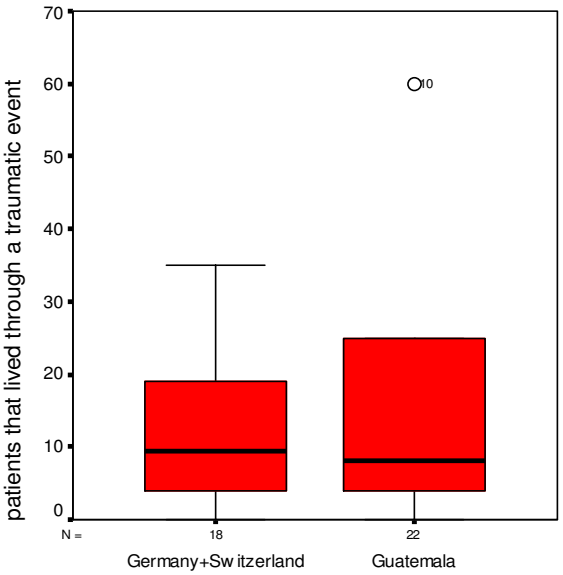

Figure 3: Number of patients that lived a traumatic event currently being treated by country.

Thirty-one (77.5%) participants rated the amount of distress after a therapy session as 2 or less in a 0 to 4 point Likert-scale. Although participants said that deciding how he or she commonly feels after a therapy session, say in an average, is almost impossible because every session turns out different, and so different feelings and diverse intensities arise. However, the results found out that most therapists indicate to feel rather less distressed after a therapy session with a traumatized patient.

Twenty-two (55%) of the psychotherapists had felt sentiments of sadness and anger after a therapeutic session with a traumatized person. Nineteen (47.5%) participants have experienced frustration, relieve and compassion feelings; 11 (27.5%) sorrow; 8 (20%) anxiety and 26 (65%) disclosed having felt achievement. As for the feelings a therapist has after a session with a traumatized patient, relieve (T= 4.043), frustration (T= 3.087) and sorrow (T= 4.258) feelings reached a higher mean for therapists from Germany and Switzerland than for those from Guatemala.

Just 4 (10%) of the subjects revealed to keep everything for themselves when they feel overwhelmed. Six (15%) psychotherapists indicated to speak to other people about something else, not the bothering topic per se. And almost all, 37 (92.5%), declared to talk to other people about the feelings and issues directly related to the bothering topic; most of them emphasising to do this only with a colleague because of the professional secrecy.

About the general state sum score, the mean in the therapists' group from Germany and Switzerland (x= 3.94) was higher than the mean from the therapists from Guatemala (x= 2.95), but this was not significant (T= 1.753).

Only 5 (12.5%) therapists showed a sign in the direction of a possible depression, as measured by the HSCL; the other participants indicated no sign of relevant clinical disorder. Thirty-nine (97.5%) of the subjects confessed that they have felt those depressing feelings at some point in their lives. And for 25 (62.5%) subjects, it is more likely to experience these types of feelings after an intense session with a traumatized patient.

Table 2 shows the kind of traumatic events lived by psychotherapists in Guatemala, and Germany and Switzerland.

Table 2: Traumatic event(s) lived or witnessed by psychotherapists.

Traumatic event	Number of therapists in Guatemala	Number of therapists in Europe	Number and % of therapists in TOTAL
experienced a serious accident	9	6	15 (37.5%)
experienced a natural disaster	17	2	19 (47.5%)
experienced non-sexual assault by a family member	3	6	9 (22.5%)
experienced non-sexual assault by a stranger	16	7	23 (57.5%)
experienced sexual assault by a family member	0	3	3 (7.5%)
experienced sexual assault by a stranger	2	5	7 (17.5%)
experienced a military combat or migration situation	7	9	16 (40%)
sexual contact under 18 years with someone 5 or more years older	7	4	11 (27.5%)
experienced adoption or foster care	4	1	5 (12.5%)
experienced imprisonment, or a hostage situation	2	2	4 (10%)
experienced torture	1	0	1 (2.5%)
experienced a life-threatening illness	5	5	10 (25%)
other (like tragical loss, persecution, exhumations)	6	6	12 (30%)

Two of the 40 participants declared that they did not live through a traumatic event, and other two therapists expressed not being affected by it anymore and could hence not choose the event that would still bother him or her the most. Table 3 describes which event was chosen by the 36 psychotherapists as still being the most bothering event perceived in the present time.

Table 3: Most bothering trauma chosen

Traumatic event	frequency	percent	cumulative percent
Accident	9	22,5	25,0
Natural disaster	3	7,5	33,3
Non sexual assault by a family member	4	10,0	44,4
Non-sexual assault by a stranger	2	5,0	50,0
Sexual assault by a family member	1	2,5	52,8
Sexual assault by a stranger	1	2,5	55,6
Combat or migration	2	5,0	61,1
Sex contact under 18	1	2,5	63,9
Adoption or fostercare	1	2,5	66,7
Imprisonment	1	2,5	69,4
life-threatening illness	3	7,5	77,8
Other	8	20,0	100,0
TOTAL	36	90,0	
Missing	4	10,0	
TOTAL	40	100,0	

The bothering traumatic event happened more than six years ago for 26 (72.2%) of these 36 therapists. Six (16.7%) therapists lived the trauma between three and five years ago, and 4 (11.1%) therapists between six months and 3 years ago. Most of them (26) were not physically injured during that bothering traumatic event; neither was someone else physically injured. In 22 (61.1%) cases the therapist thought his or her live was in danger; and in 16 (44.4%) cases thought the life of someone else was in danger. Twenty-six 26 (72.2%) therapists indicated that they felt helpless; and the same amount of confirmations was measured for the question if the therapist felt terrified during that specified event.

Two (5%) therapists filled all the criteria for a PTSD diagnosis and 2 had PTSD-like symptoms. Five (12.5%) psychotherapists, who in spite of not showing PTSD-like symptoms, indicated feeling interfered in at least one area of their life. All psychotherapists agreed that they have felt some of the PTSD-symptoms at one point after the traumatic event but now they have gone away.

Nine of the 11 items from the work-related statement part turned out to be not significant on $p < .05$. However, “giving testimony brings always at least some relief to the eyewitness” ($T=-3.549$) was significant ($p < .05$); the group from Guatemala ($x= 4.45$) rated this item higher than the therapists from Europe ($x= 2.89$). The statement “interviewing eyewitnesses often tends to upset them emotionally” ($T= 3.020$), was rated higher by the European ($x= .383$) group than by the Guatemalan ($x= .223$).

There was no significant ($p<.05$) difference in the theoretical approach used by both groups, except for the counselling approach ($T= 4.289$); this one was indicated to be used more often by the psychotherapists from Germany and Switzerland.

Psychotherapists from Guatemala indicated having more contact with traumatized persons outside their work settings, as can be seen in the following 2 tables:

Table 4: Contact with traumatized persons outside the work setting -Guatemala

	Frequency	Percent	Valid Percent	Cumulative Percent
no	4	18,2	18,2	18,2
yes	18	81,8	81,8	100,0
Total	22	100,0	100,0	

Table 5: Contact with traumatized persons outside the work setting -Europe

	Frequency	Percent	Valid Percent	Cumulative Percent
no	9	50,0	50,0	50,0
yes	9	50,0	50,0	100,0
Total	18	100,0	100,0	

In the Table 6 and 7 one can observe that both groups thought, in about 78%, that at least most problems that traumatized patients have are product of the traumatic experiences the patient had.

Table 6: Problems that traumatized patients have as a product of their trauma -Guatemala

	Frequency	Percent	Valid Percent	Cumulative Percent
some of them	4	18,2	18,2	18,2
most of them	13	59,1	59,1	77,3
all	5	22,7	22,7	100,0
Total	22	100,0	100,0	

Table 7: Problems that traumatized patients have as a product of their trauma - Europe

	Frequency	Percent	Valid Percent	Cumulative Percent
some of them	4	22,2	22,2	22,2
most of them	14	77,8	77,8	100,0
Total	18	100,0	100,0	

The most frequent topics heard by psychotherapists interviewed in Germany and Switzerland are displayed in Figure 4. One can observe the most often thematic encountered in therapy being combat stories; followed by torture; and sexual assault by someone the victim knew.

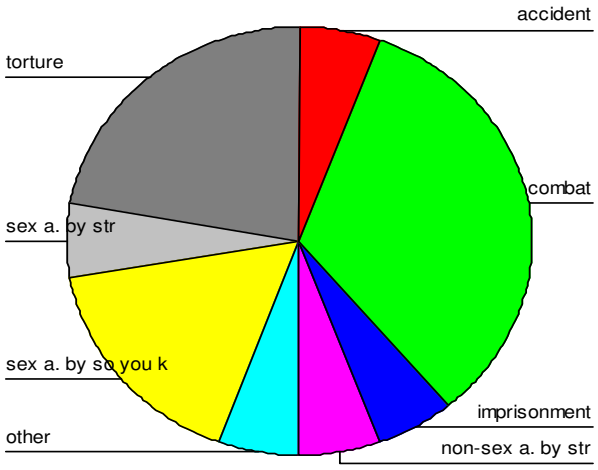

Figure 4: most frequent topic of patients in Germany and Switzerland.
Note: non-sex a. by str = a non-sexual assault by someone the victim did not know. Sex a. by str = a sexual assault by someone the victim did not know. Sex a. by so you k = a sexual assault by someone the victim did know, e.g. a family member or acquaintance. Other = e.g. tragic lost of a loved one, problems with the authorities and government bureaus, separation.

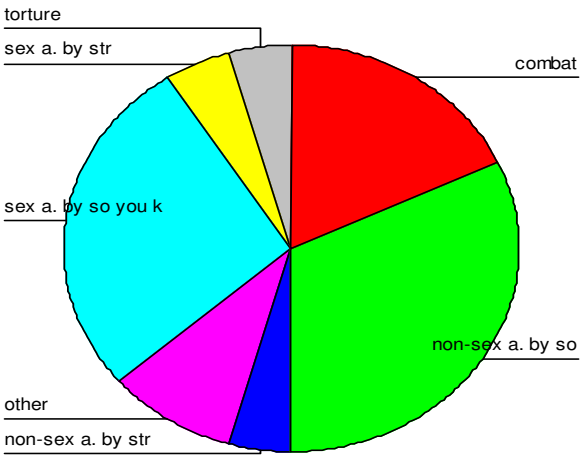

Figure 5: most frequent topic of patients in Guatemala.
Note: non-sex a. by so = a non-sexual assault by someone the victim did know, e.g. a family member. Non-sex a. by str = a non- sexual assault by someone the victim did not know. Sex a. by so you k = a sexual assault by someone the victim did know, e.g. a family member or acquaintance. Sex a. by str = a sexual assault by someone the victim did not know. Other = e.g. tragic lost of a loved one, separation/divorce.

The most frequent topics heard by psychotherapists interviewed in Guatemala as displayed in Figure 5 are non-sexual assault by a stranger and by someone the victim knew. Combat and other themes like tragic loss, separation and violence do follow.

The descriptive statistic for the secondary traumatization part of the interview indicates that 75% of the therapists from this study do think about the story of their patients between 0 and 10 times in a month. The other 25% thought about the stories at least 11 times to every day. Twenty-nine (72.5%) of the psychotherapists did experience intense feelings about these stories. The most reported were anger, sadness, sorrow, empathy and also frustration. But only 7 participants (17.5%) felt that these feelings had created obstacles in their private life.

Twenty-nine (72.5%) of the therapists did experience what their patients told them in images and 31 (77.5%) did experience the patients' tellings in emotions. Only 7 participants (17.5%) experienced what their patients told in 1st person perspective, but almost all subjects, 38 out of 40 (95%), did experience the stories from a 3rd person perspective, like an outside standing spectator.

Twenty-two (55%) of the therapists did not at all have to try not to think about a patient's story, 14 (35%) did not have to try so hard for not thinking about a patient's story, and 4 participants (10%) did try very hard for not thinking about a patient's telling.

Twenty-seven (67.5%) of the therapists did not at all develop physical reactions towards their patients' stories, 12 (30%) did not so much either, and 1 participant (2.5%) indicated having a lot of physical reactions about his patients' stories.

Almost all participants, 36 (90%) of the therapists, denoted not to avoid patients with history of trauma, 3 (7.5%) did sometimes, and 1 participant (2.5%) indicated avoiding them. The same figures were taken for the question "do you feel internally distant from a traumatized patient?" (90% answered with no, 7.5% with sometimes and 2.5% with yes). Twenty-one (52.5%) therapists indicated that their emotions got connected to stories their patients told them, although in 13 cases the answer was sometimes.

Finally, no discrepancies were noticed when psychotherapists answered to the question at the end of the interview "How do you feel after this interview?"; both groups answered to 82% that they felt calm and/or relieved.

3. 2 Hypothesis 1a

> Therapists identified as working trauma-focused are at higher risk of experiencing secondary traumatization than psychotherapists having a symptom-relieving working style.

The question at the beginning of the interview "what kind of therapy do you use? (e.g. 20:80) please, give a relation" served to divide the participants into two groups. Cut-off point for symptom-relievers was 50 or more percent focus on symptoms during their therapy and therefore just 49 or less percentage on the focus of the traumatic event per se. And trauma-focused therapists used 49 percent or less time of their therapy to treat symptoms the patient has nowadays and therefore are careful to use more than 50 percent of the therapy time to talk about the traumatic event of the patient. Twenty-four (60%) of the psychotherapists identified themselves as symptom-relievers, the rest of them (40%) identified themselves as having a trauma-focused working style.

A t-test for independent samples was done with the three subscale scores from the Professional Quality of Life Self-test (Burnout, Compassion Fatigue and Compassion Satisfaction), and two items from the work-related statement part, that were believed to distinguish between symptom and trauma-focused therapists. As alluded in the methods section, not all therapists did make the Professional Quality of Life Self-test. So the total number of therapists for these testing was 32.

In Table 8 one can observe the results for the t-test. None of the results was significant for $p < .05$. The hypothesis could not be accepted.

Table 8: Independent Samples Test

		Levene-Test der Varianzgleichheit		t-test for Equality of Means			
		F	Signifikanz	t	df	Sig. (2-tailed)	Mean Difference
BURNOUT	Equal variances assumed	,374	,546	-,861	29	,396	-2,30
CF	Equal variances assumed	,021	,885	-,879	29	,386	-5,17
CS	Equal variances assumed	1,485	,233	-,552	29	,585	-3,82
interviewer should be empathic	Equal variances assumed	,000	,987	-,137	38	,891	-,02
giving testimony brings some relief to eyewitness	Equal variances assumed	,000	,987	-1,233	38	,225	-,63

Furthermore, presence of possible depression in the symptom-reliever and trauma-focused group was examined. Table 9 shows the figures of the crosstabulation and Table 10 the result of the chi square test. Again, no significance (p< .05) was found.

Table 9: HSCL - Depression * working style Crosstabulation

		working style		
		symptom-relieving	trauma-focused	total
HSCL	no	21	14	35
	yes	3	2	5
total		24	16	40

Table 10: Chi-Square Tests

	Wert	df	Asymptotische Signifikanz (2-seitig)
Pearson Chi-Square	,000(b)	1	1,000

(b) 2 cells (50,0%) have expected count less than 5. The minimum expected count is 2,00.

PTSD-like symptoms (intrusion, avoidance, arousal); disclosure, closure and negative affect scores; the family of origin score; the general feeling of restlessness score; percentage of total time talked about the traumatic event during therapy; patients in total and patients who lived a traumatic event; and sessions per week were also tested. The t-test displayed in Table 11 shows that the groups defer at the family of origin score (t= -2.150, p< .05). The trauma-focused therapists (x= 13.56) had a higher mean for this score than the symptom-relieving (x= 10.50) psychotherapists. The item asking for the percentage of total time talked about the traumatic event during therapy (t= -2.956) was significant at p< .01. The trauma-focused group (x= .5219) indicated a higher mean for the percentage of total time talked about a trauma during treatment than the symptom-relieving group (x= .3542), as logic would have foreseen it. Accurately this means that the symptom-relievers talked about the traumatic event for about 35% (in average) of the time they have in therapy, whilst trauma-focused therapists talk about the trauma of the patient for about 52% of the time in therapy.

Table 11: Independent Samples Test

		t-test for Equality of Means				
		t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
INTRUSIO	Equal variances assumed	-,983	33	,333	-,60	,605
AVOIDANC	Equal variances assumed	,552	33	,584	,43	,776
AROUSAL	Equal variances assumed	-,163	33	,872	-,10	,584
want disclosure	Equal variances assumed	-,265	33	,792	-,43	1,615
closure	Equal variances assumed	1,509	33	,141	1,93	1,278
negative affect after disclosure	Equal variances assumed	-,976	33	,336	-1,26	1,292
SUM of FAMILY SCORE	Equal variances assumed	-2,150	38	,038	-3,06	1,424
general restless feeling/state	Equal variances assumed	1,137	38	,263	,67	,586
number of psychological interviews undertaken	Equal variances assumed	-1,124	38	,268	-,38	,334
sessions per week currently	Equal variances assumed	,752	38	,457	2,06	2,744
patients in total	Equal variances assumed	,251	38	,803	3,21	12,770
those patients who have lived through a trauma event	Equal variances assumed	-,186	38	,853	-2,40	12,857
percentage of total time talked about a traumatic event during therapy	Equal variances assumed	-2,956	38	,005	-,1677	,05674

To work in an institution for victims of organized crime or not, showed no difference at all in the variance of these variables.

3. 3 Hypothesis 1b

Supervision does protect from secondary traumatic stress.

The hypothesis supervision does protect from secondary traumatic stress was accepted. The t-test in Table 13 shows that the means of the scores of the Professional Quality of Life Self-Test were different on a significant ($p < .01$) level; the homogeneity of the variances was not refused in any case. One can clearly observe in Table 12 that the group with no supervision had higher scores in the Burnout, Compassion Fatigue and Compassion Satisfaction Subscales.

Table 12: Group Statistics.

	supervisions	N	Mean	Std. Deviation	Std. Error Mean
BURNOUT	no supervision	12	29,82	6,570	1,981
	supervision	20	22,95	6,337	1,417
CF	no supervision	12	36,36	12,524	3,776
	supervision	20	16,75	12,941	2,894
CS	no supervision	12	62,45	12,926	3,897
	supervision	20	39,00	15,821	3,538

Table 13: Independent Samples Test

	t-test for Equality of Means						
	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
						Lower	Upper
BURNOUT	2,851	29	,008	6,87	2,409	1,941	11,796
CF	4,083	29	,000	19,61	4,804	9,788	29,440
CS	4,197	29	,000	23,45	5,588	12,026	34,884

3. 4 Hypothesis 2a

> Higher secondary traumatization scores and lesser supervision in the group interviewed in Guatemala than in the group interviewed in Switzerland and Germany.

A t-test for independent samples was done with the three subscale scores from the ProQOL Self-test (Burnout, Compassion Fatigue and Compassion Satisfaction), and the two items from the work-related statement part; as was done in hypothesis 1a (but at that time to test the SR-TF concept). In Table 14 one can observe the groups' statistic and in Table 15 the results for the t-test.

Table 14: Group Statistics

		N	Mean	Std. Deviation	Std. Error Mean
BURNOUT	Germany+Switzerland	18	21,22	6,083	1,434
	Guatemala	14	32,23	1,301	,361
CF	Germany+Switzerland	18	10,61	4,381	1,033
	Guatemala	14	41,54	1,506	,418
CS	Germany+Switzerland	18	32,22	5,526	1,302
	Guatemala	14	68,23	1,423	,395
interviewer should be empathic	Germany+Switzerland	18	4,83	,383	,090
	Guatemala	22	4,77	,528	,113
giving testimony brings some relief to eyewitness	Germany+Switzerland	18	2,89	1,641	,387
	Guatemala	22	4,45	1,143	,244

In Table 15 one can observe that the means of secondary traumatic stress of the groups are significantly different from each other at the high level of $p<.01$. The European group has a mean of 21.22 for burnout while the Guatemalan group shows a higher mean ($x= 32.23$). The same can be said for compassion fatigue ($x= 10.61$, $x=41.54$) and compassion satisfaction ($x= 32.22$, $x= 68.23$); the Guatemalan mean is always higher than the mean for therapists from Germany and Switzerland.

The item “giving testimony always brings at least some relieve to the eyewitness” also showed a significant higher mean for the group from Guatemala ($x= 4.45$) than for the group from Europe ($x= 2.89$).

Table 15: Independent Samples Test

		t-test for Equality of Means			
		t	df	Sig. (2-tailed)	Mean Difference
BURNOUT	Equal variances assumed	-7,915	30	,000	-11,01
CF	Equal variances assumed	-21,307	30	,000	-29,95
CS	Equal variances assumed	-16,336	30	,000	-34,35
interviewer should be empathic	Equal variances assumed	,406	38	,687	,06
giving testimony brings at least some relief to the eyewitness	Equal variances assumed	-3,549	38	,001	-1,57

Following next, in Figure 6, is a visualization of the scores the psychotherapists obtained in these three subscales: Burnout, Compassion Fatigue and Compassion Satisfaction.

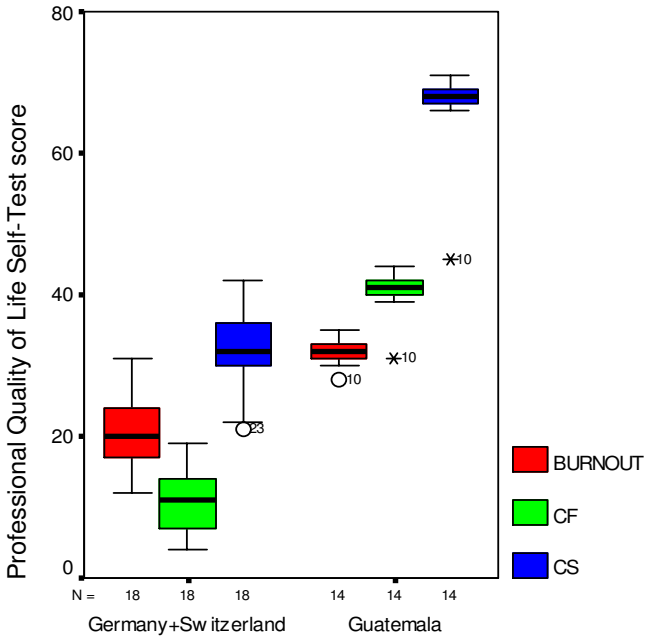

Figure 6: BO, CF and CS by country.

Then, frequencies of supervision were counted; in Table 16 one can notice that just 22.7% of the psychotherapists in Guatemala had supervision, compared to 88.9% in Germany and Switzerland (Table 17). A t-test indicated significant ($p < .01$) discrepancy in the index of supervision between the countries ($t = 5.558$): psychotherapists in Guatemala have far less supervision than their colleagues in Europe .

Table 16: Supervision in Guatemala

	Häufigkeit	Prozent	Kumulierte Prozente
no supervision	17	77,3	77,3
supervision	5	**22,7**	100,0
Gesamt	22	100,0	

Table 17: Supervision in Europe

	Häufigkeit	Prozent	Kumulierte Prozente
no supervision	2	11,1	11,1
supervision	16	**88,9**	100,0
Gesamt	18	100,0	

Figure 7 and 8 below do further stand out the differences in supervision between the countries.

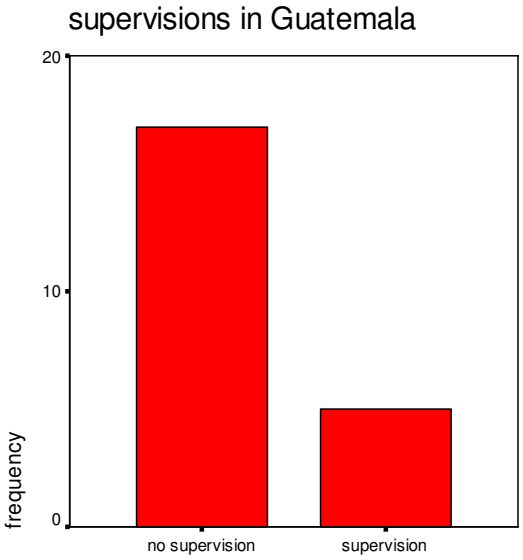

Figure 7: Frequency of supervision in Guatemala.

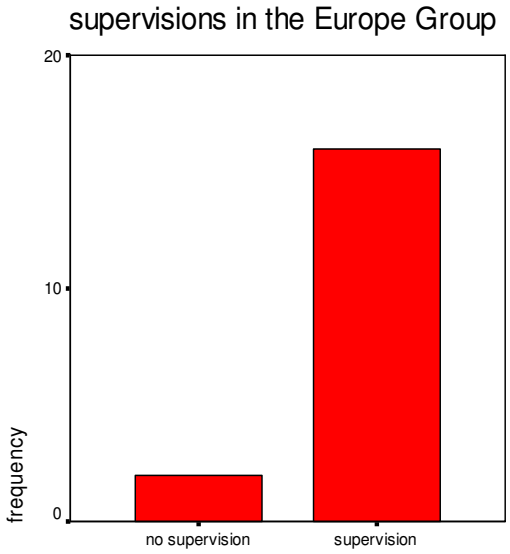

Figure 8: Frequency of supervision in Europe

3. 5 Hypothesis 2b

> Differences in disclosure; HSCL-depression; PTSD-like symptoms; and family of origin between the group interviewed in Guatemala and the group interviewed in Switzerland and Germany.

A t-test was run for the variables of the disclosure construct: want disclosure (t= -.885); closure (t= .615); and negative affect (t= 1.194); no significance ($p<.05$) was found. Risk for Depression (t= -1.193); intrusion (t= -.468); avoidance (t= -.303); and arousal (t= -.755) were also tested, no significance. Just the family of origin score (t= -4.201) showed a significant ($p<.05$) disparity. The mean of the therapist group from Guatemala (x= 14.05) was higher than the mean of therapists interviewed in Germany and Switzerland (x= 8.89).

3. 6 Hypothesis 3

> Trauma-focused and symptom-relieving psychotherapists in Germany and Switzerland have a bigger within group discrepancy in variables of secondary traumatization than do those psychotherapists in Guatemala.

An univariate analysis of variance model was chosen to compare the variances of these four groups (trauma-focused, symptom-relieving, Guatemalan group, and German-Swiss group). The variables burnout; compassion fatigue and satisfaction; risk for depression; and distress after a therapeutic session with a traumatized patient were tested. No differences between the variances were significant (see example Burnout displayed in Table 18); but the most interesting graphics that may anyhow uphold the symptom-relieving versus trauma-focused concept (SR-TF-concept) are shown below.

Table 18: Tests of Between-Subjects Effects. Dependent Variable: BURNOUT

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	1097,969(a)	3	365,990	23,397	,000
Intercept	20776,013	1	20776,013	1328,147	,000
GUATE	873,346	1	873,346	55,830	,000
TRAUMAFO	33,346	1	33,346	2,132	,155
GUATE * TRAUMAFO	21,551	1	21,551	1,378	,250
Error	438,000	28	15,643		
Total	22293,000	32			
Corrected Total	1535,969	31			

a R Squared = ,715 (Adjusted R Squared = ,684)

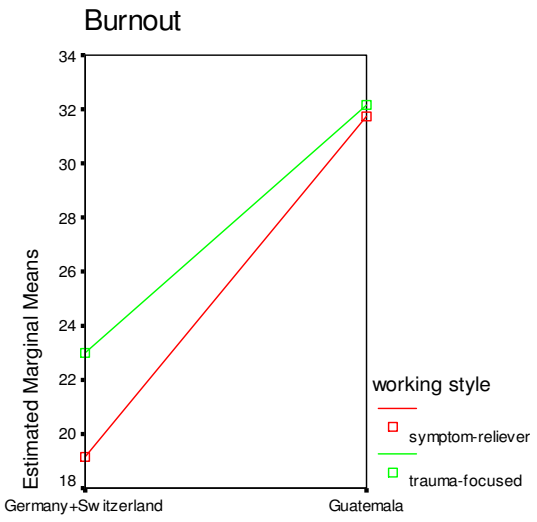

Figure 9: Estimated marginal means for Burnout by country and working style.

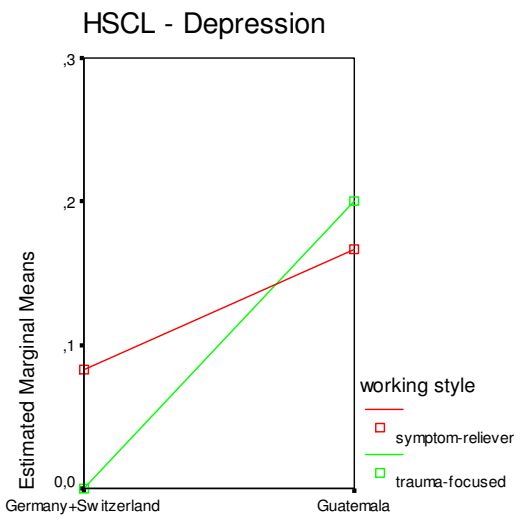

Figure 10: Estimated marginal means for risk of depression by country and work style.

One can observe a bigger difference between the variances of the symptom-reliving and trauma-focused therapist within Germany and Switzerland than the variance of symptom-reliver and trauma-focused within Guatemala. These two graphics reinforce the theoretical thought that TF therapists would differ from SR therapists with regard to secondary traumatization but, if ever, ONLY valid for psychotherapists in Europe. This point will be dealt with in more detail in the discussion section.

More arguments in favour of the possible occurrence of symptom-relieving versus trauma-focused differentiation are shown in the following two graphics (Figure 11 and 12). The openness of the therapists when looking at the variable of wanting disclosure indicates a difference between the variances within the country variable. Again it was higher for therapists in Germany and Switzerland, even though it was not significant for the psychotherapists in this study.

In the case of negative affect after disclosing, the means of trauma-focused therapists both were higher than the means of symptom-relievers. But the variance of trauma-focused and symptom-relieving psychotherapists *within* Europe was much higher than the variance of TF and SR within Guatemala.

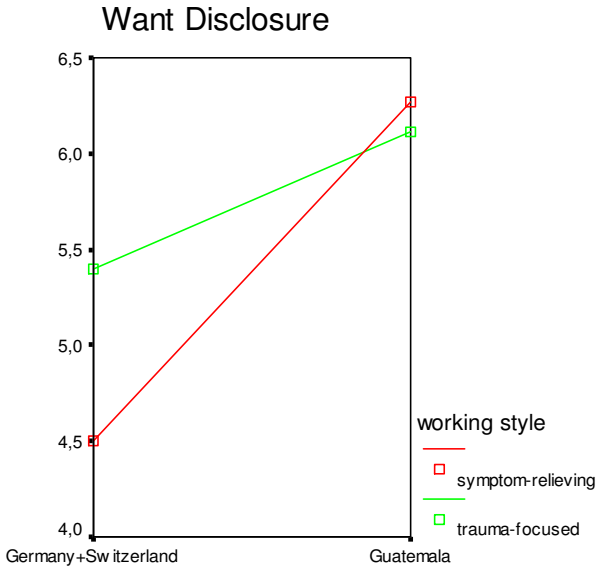

Figure 11: Estimated marginal means for Want Disclosure by country and work style.

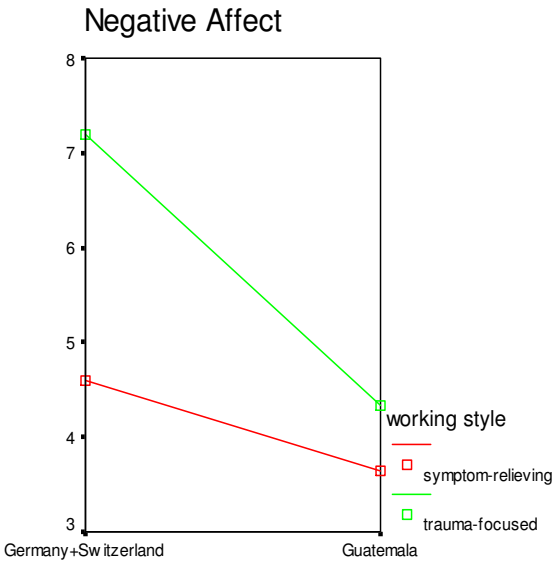

Figure 12: Estimated marginal means for Neg Affect by country and work style.

3. 7 Hypothesis 4a

> Disclosure rates; general feeling; family of origin; and PTSD-like symptoms in psychotherapists are different from those measured in students entering university.

Disclosure rates in psychotherapists were compared to those rates given by students entering the Florida State University using t-tests. The results, as can be seen in the tables below, were significant for the means of these two independent groups in regard with wanting to disclose a traumatic event (t= 1.996, p< .05) and closure (t= 5.334, p<.01). More precisely, this means that students indicated higher closeness to mention the traumatic event (x= 6.50) and higher scores for the items measuring want to disclose (x= 6.50) than do the psychotherapists (x= 2.94 for closure and x= 5.60 for want disclosure). No significance was found for negative affects developed when talking about the distressing event.

Table 19: Group Statistics

		N	Mean	Std. Deviation
WANT DISCLOSURE	Student	912	6,78	3,385
	Therapist	35	5,60	4,616
CLOSURE	Student	912	6,50	3,869
	Therapist	35	2,94	3,773
NEGATIVE AFFECT	Student	912	4,47	2,725
	Therapist	35	4,60	3,743

Table 20: Independent Samples Test

		t-test for Equality of Means						
		t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
							Lower	Upper
WANT DISCLOSURE	Equal variances assumed	1,996	957	,046	1,18	,592	,020	2,343
CLOSURE	Equal variances assumed	5,334	929	,000	3,55	,666	2,246	4,860
NEGATIVE AFFECT	Equal variances assumed	-,276	945	,782	-,13	,477	-1,067	,804

With regard to the three symptoms, characteristic for PTSD, a significant ($p < .01$) difference was found between the means of intrusion ($t = 4.434$), avoidance ($t = 5.981$) and arousal ($t = 3.896$). These were rated significantly higher by students than by the therapists of this study. Also the general feeling of restlessness was significantly ($p < .05$) higher in students ($x = 6.77$) than in the psychotherapists ($x = 3.40$) of this study, as can be observed in the group statistics of Table 21. The family of origin score presented no significance. Table 22 exhibits the t-scores for the five variables tested.

Table 21: Group Statistics

		N	Mean	Std. Deviation
GENERAL STATE	Student	970	6,77	3,832
	Therapist	40	3,40	1,823
SUMFAMILY	Student	970	10,84	1,705
	Therapist	40	11,73	4,613
INTRUSION	Student	920	2,83	3,246
	Therapist	35	1,43	1,754
AVOIDANCE	Student	920	3,81	4,376
	Therapist	35	1,40	2,226
AROUSAL	Student	920	2,74	3,358
	Therapist	34	1,53	1,692

Table 22: Independent Samples Test

		t-test for Equality of Means			
		t	df	Sig. (2-tailed)	Mean Difference
GENERAL STATE	Equal variances not assumed	10,739	54,454	,000	3,37
SUMFAMIL	Equal variances not assumed	-1,214	39,440	,232	-,89
INTRUSION	Equal variances not assumed	4,434	43,410	,000	1,40
AVOIDANCE	Equal variances not assumed	5,981	44,704	,000	2,41
AROUSAL	Equal variances not assumed	3,896	43,300	,000	1,21

3. 8 Hypothesis 4b

Psychotherapists that disclose less have less secondary traumatization.

The burnout score was used to create two groups, in one group are the therapists who have burnout and the other one those who do not. Twenty-nine was taken as the cut-off point, like recommended by the authors of the self-test. T-tests were run for the variables want disclosure (t= .706), closure (t= -.137) and negative affect (t= .563). None was significant to p< .05 level.

Also the compassion fatigue score was used to create two groups, one group had 28 points or more and the other one had less than 28 points (recommended cut-off by the authors). T-tests were not significant (p< .05) for the variables want disclosure, closure and negative affect (t= 1.181, t= -.469 and t= -1.173 respectively).

No t-test was possible for the compassion satisfaction score because no participant showed low compassion satisfaction; no subject had 19 points (cut-off point) or less. Since no results of the t-test were significant, the hypothesis could not be accepted.

3. 9 Hypothesis 4c

Correlations between disclosure and PTSD-like symptoms.

The relationship between disclosure and PTSD-like symptoms was analyzed with a Spearman's rho correlation matrix, all significant correlations were positive. As can be observed below, intrusion, closure and negative affect after disclosing, each correlated positively with all other five variables. Additionally, avoidance positively correlated with intrusion (r= .437, p< .01), closure (r= .452, p< .01) and negative affect after disclosing (r= .383, p< .05). Also arousal correlated with intrusion (r= .449, p< .01), closure (r= .341, p< .05) and negative affect (r= .484, p< .01). The PTSD-symptoms avoidance and arousal did not correlate with each other (but, as just mentioned, both correlated with intrusion). And wanting disclosure correlated with intrusion (r= .461, p< .01), closure (r= .533, p< .01) and negative affect after disclosing (r= .494, p< .01).

The three disclosure constructs all correlated positively among themselves. The correlations were between r= .494 and r= .604, all significant at the .01 level.

Table 23: Spearman's rho Correlations.

		INTRUSION	AVOIDANCE	AROUSAL	WANT DISC	closure	NEG AFFECT
INTRUSION	Correlation Coefficient	1,000	,437(**)	,449(**)	,461(**)	,342(*)	,629(**)
	Sig. (2-tailed)	.	,009	,007	,005	,044	,000
	N	35	35	35	35	35	35
AVOIDANCE	Correlation Coefficient	,437(**)	1,000	,308	-,061	,452(**)	,383(*)
	Sig. (2-tailed)	,009	.	,072	,729	,006	,023
	N	35	35	35	35	35	35
AROUSAL	Correlation Coefficient	,449(**)	,308	1,000	,306	,341(*)	,484(**)
	Sig. (2-tailed)	,007	,072	.	,074	,045	,003
	N	35	35	35	35	35	35
WANT DISC	Correlation Coefficient	,461(**)	-,061	,306	1,000	,533(**)	,494(**)
	Sig. (2-tailed)	,005	,729	,074	.	,001	,003
	N	35	35	35	35	35	35
closure	Correlation Coefficient	,342(*)	,452(**)	,341(*)	,533(**)	1,000	,604(**)
	Sig. (2-tailed)	,044	,006	,045	,001	.	,000
	N	35	35	35	35	35	35
NEG AFFECT	Correlation Coefficient	,629(**)	,383(*)	,484(**)	,494(**)	,604(**)	1,000
	Sig. (2-tailed)	,000	,023	,003	,003	,000	.
	N	35	35	35	35	35	35

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

3. 10 Hypothesis 5

> Therapists that have lived through a traumatic event themselves are more vulnerable or predisposed to suffer from secondary traumatization, than those who have no personal trauma history.

No statistic was possible due to the fact that only 4 therapists indicated not having lived a traumatic event.

3. 11 Factor Analysis

A factor analysis (VARIMAX rotation) was done with most of the variables from the secondary traumatization part of the interview; the BO, CF and CS scores; intrusion, avoidance and arousal, characteristics of PTSD; the HSCL-depression variable; supervision; general state feeling; years of experience with traumatized patients; distress after a therapy session; and the three variables to estimate the degree of disclosure: want disclosure, closure and negative affect. The variables from the secondary traumatization part of the interview here included were: avoid patients with history of trauma; experience what patient tells in emotions; how hard the therapist tries not to think about his patients' stories; own emotions become connected with the patient's telling; experience what the patient tells in 1st person; and experiences the telling in 3rd person. In Table 24 we can contemplate the explained variance and in Table 25 the rotated component matrix.

Table 24: Total Variance Explained

Component	Initial Eigenvalues			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5,350	26,749	26,749	5,113	25,564	25,564
2	4,016	20,078	46,827	4,039	20,193	45,757
3	2,069	10,344	57,171	2,283	11,414	57,171
4	1,793	8,963	66,134			
5	1,353	6,765	72,899			
6	1,214	6,068	78,967			
7	1,117	5,583	84,550			
8	,852	4,260	88,810			
9	,561	2,805	91,615			
10	,423	2,113	93,728			
11	,296	1,479	95,207			
12	,283	1,417	96,623			
13	,231	1,153	97,776			
14	,144	,720	98,496			
15	,116	,580	99,076			
16	,110	,550	99,626			
17	,034	,172	99,799			
18	,021	,107	99,906			
19	,015	,074	99,980			
20	,004	,020	100,000			

Extraction Method: Principal Component Analysis.

As can be observed in Table 25, the PTSD-symptoms, closure, negative affect and wanting disclosure, all load together on the first factor. This finding is similarly to those found by Elbert and his colleagues in an unpublished study with students from the Florida State University; this will be discussed in detail in the next section.

Additionally, the general feeling state; experiencing what the patient tells from a 1st person perspective; and the own emotions from the therapist connecting to the patient's telling also load positively on the first Factor (F1). Experiencing what the patient tells in a 3rd person perspective, from an outside position, had a negative load on F1. Together, this factor explained 25.56% of the variance. I like to call this factor the openness factor, the openness to move into the patient's perspective.

Table 25: Rotated Component Matrix(a)

	Component		
	1	2	3
AROUSAL	,863	,073	-,127
AVOIDANCE	,862	,005	-,179
experience what patient tells in 3rd person	-,834	-,189	,120
INTRUSION	,833	,169	-,002
Want disclosure	,663	,324	,103
Negative affect	,642	-,131	,217
Closure	,600	-,080	,091
general feeling restless	,533	-,343	,276
experience what patient tells in 1st person	,408	-,364	-,140
own emotions become connected with patient's telling	,269	-,007	,143
CF	,044	,974	-,096
CS	,015	,950	-,145
BURNOUT	,017	,864	,005
supervision	-,163	-,651	,045
years of experience with traumatized patients	-,164	-,577	,434
experience what patient tells in emotions	,053	-,245	-,160
avoid patients with history of trauma	,053	,096	,855
distress feelings after therapy session	,142	-,260	,703
HSCL - Depression	,578	,287	,673
how hard tries NOT to think about patients' stories	-,295	-,126	,336

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.
a Rotation converged in 5 iterations.

The second factor was identified as secondary traumatization. It includes the positive load of BO, CF, CS; and the negative load of supervision, the years of experience with traumatized patients specifically, and the experience in emotions of what the patient tells. F2 accounts for 21.20% of the variance. In other words, the more burnout, compassion fatigue and compassion satisfaction the less supervision and years of experience the therapist will have; plus lesser experimentation of emotions towards the patient's tellings.

On the third factor all four variables loaded positively: avoidance of patients with trauma history, distress feelings after a therapy session with a traumatized patient, HSCL-depression and how hard the therapist tries not to think about the patients' stories. This last factor was named unease feeling. It explained 10.41% of the variance. The more signs of risk for a clinical relevant depression disorder, the more distressing feelings may the therapist feel after a session with a traumatized patient, and will even more avoid patients with history of trauma. Moreover, a slightly higher probability subsists that the psychotherapist tries hard for not thinking about the stories of his or her patients.

All three factors together explained 57.17% of the variance in psychotherapists from Guatemala, Germany and Switzerland.

When doing the factor analysis, there could not be found any relation between professional experience; number of patients; and degree of burden (BO, CF). In other words, burden was not connected to workload, or number of patients and appointments per week, nor overall years of experience in the professional field.

4. Discussion

The purpose of this study was to examine secondary traumatization in psychotherapists working with victims of violence. Secondary traumatization variables and other related factors were analysed for working style on the one hand and for country differences on the other hand. The present discussion covers seven principal topics Primarily, I offer a view on the results of the general descriptive data. Secondly, I investigate the TF-SR concept. Thirdly, I comment upon the cultural differences observed in this study sample. Fourthly, I analyse the scores measured in university students (data from another study project) with those scores obtained by the psychotherapists in this study. Fifthly, I further interpret the results of the factor analysis. Straight after that I outline the limitations and further research. And finally, I close this work with recommendations for prevention of secondary traumatization.

The descriptive data of the interviews revealed that no therapist has never ever experienced negative effects when working with severely traumatized clients. These responses were predominantly affective in nature; namely anger, pain, frustration, sadness, and distress. This further supports assertions made in the introduction that VT is an unavoidable result of trauma counselling (McCann and Pearlman, 1990).

Four (11.1%) of the therapists of this study had PTSD; this is in accordance with data of a cross-cultural study by Lansen (1993) where the therapists' population, therapists treating victims of torture and persecution, showed an 11% occurrence. Different are the figures for PTSD among American adults (general population), where the prevalence is 7.8% (Figley, 2002b; Teegen, 2003). In other words, the prevalence of PTSD is higher among therapists working with survivors of violence, than in the general adult population of the USA.

In the present study, 5 (12.5%) therapists displayed a potential risk of depression. If we compare this figure with data of the cross-cultural study mentioned above, 7.5% of depression prevalence (Lansen, 1993), we can observe almost twice as much probability of depression in this study's sample.

4.1 TF-SR-Concept

My *first hypothesis*, that therapists identified as working trauma-focused are at higher risk of experiencing secondary traumatization than psychotherapists having a symptom-relieving working style, could not be accepted. Indeed, the instrument chosen to measure secondary traumatic stress (Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales-III) does not appear suitable for distinguishing, within a same country, therapists who do have burnout or compassion fatigue from those who do not. This conclusion is drawn from the fact that in the group from Germany and Switzerland no psychotherapist had burnout neither compassion fatigue, yet in the group from Guatemala every therapist did. In this sample, the ProQOL instrument also failed to distinguish therapists with burnout from those with CF or the other way around. There was no case where a participant had BO but no CF or vice versa.

One criticism of the instrument of Compassion Fatigue Self-Test for Psychotherapists (CFST) comes from Jenkins and Baird (2002). They write that the CFST-Burnout subscale in particular needs re-examination or conceptual reformulation; its low correlation with the Maslach Burnout Inventory “makes it a questionable measure of burnout” (Jenkins & Baird, 2002, p. 431). The author of the current study joins this opinion in the sense that in this case, it is the Professional Quality of Life Self-test which requires a review. This is particularly important if the test was designed to help therapists to differentiate between BO and CF. Another possible explanation for the ineffectiveness of this instrument is the fact that the short version used in this study is new (from may 2003) and may therefore need further research to be as efficient as its precursor the CSF (Compassion Satisfaction and Fatigue Test, Stamm & Figley, 1996).

Even though TF and SR therapists showed no difference in their STS scores; there was a significant difference between the means of symptom-relieving therapists and trauma-focused therapists in regard with their respective exposure to traumatic material. As expected, the TF were more exposed to traumatic material, because they use more of their time in therapy to talk about the traumatic event of the patient. Indeed, a bigger amount of exposure to trauma material surely signifies a bigger kind of burden. For this reason, it was expected that trauma-focused therapists would have more BO and CF. But as described in the previous paragraphs, this could not be demonstrated.

An additional argument in support of the assertion that TF therapists are more exposed because they prefer disclosure is the significant discrepancy obtained in the family of origin variable. TF psychotherapists got the higher scores of both groups. This could be an argument in favour that early familial life-experiences of a therapist form his or her character of openness. The idea that the trauma-focused therapist would be more open than the SR, would have been further supported if the variable of wanting disclosure would have also rated significantly higher for the TF group.

At first it seemed that the concept of symptom-relieving vs. trauma-focused was not sufficient to explain the incidence of secondary traumatization in psychotherapists. The fact that the *hypothesis 1a* was not accepted does not mean that it can be refuted. Furthermore, results of the *hypothesis 2a* opened the possibility that the SR-TF differentiation could exist within a same country (see country variable part, next below). *Hypothesis 3* should have further reinforced the theoretical thought that TF therapists differ from SR therapists with regard to secondary traumatization even though this difference may only exists for psychotherapists in Europe. But the univariate analysis of variance found no significant results. Still, the graphics visualize that the idea of symptom-relieving having less ST than trauma-focused therapists could be true for Germany and Switzerland (inspection of the means only, not statistical significance!). Additionally, the graphics of the variables want disclosure and negative affect also illustrate that the TF-SR discernment could be true within Germany and Switzerland. Again, the variances of the estimated marginal means within a country, although they did not achieve a level of significance in this study, were greater for the therapists in Europe than for those in Guatemala. This does leave hope for future research to find significant results, for instance with a bigger study sample.

4.2 Country Variable

Hypothesis 2a was accepted: secondary traumatization is greater in psychotherapists from Guatemala. A point that could explain the big between country discrepancies of the ProQOL Self-test subscales' scores is that the instrument is highly influenced by cultural differences.

Hypothesis 2a indicated that, at a very significant level, therapists in Guatemala had more secondary traumatization than their colleagues in Germany and Switzerland. To explain the biggest mean difference of the three subscales, in this case it was the Compassion Satisfaction Subscale which exhibited the greatest score; one could argue that the more BO and CF a therapist has the more CS he or she will derive from his or her job. Which is good, because then therapists who have more secondary traumatic stress, will not abandon their profession so easily due to the fact that they also receive so much satisfaction from it.

To explain the higher scores of BO and CF among Guatemalan therapists, the item "giving testimony brings at least some relief to the eyewitness" could help. The higher the rate on this item the more exposure the therapist will probably have, because he or she will encourage the patient to disclose and confront the traumatic event during therapy. Since the results found out that psychotherapists in Guatemala had a higher rate in this item than their European counterpart, it sounds logic that they will be more burned out and have more CF (than therapists in Germany and Switzerland).

An alternative explanation to the exposure degree discussed above could be that the answering patterns of both country groups are "out of tune". This means that the sample from Guatemala has a higher starting point when rating the items from the Professional Quality of Life Self-test than does the sample form Germany and Switzerland. Due to cultural differences between the samples, the groups could have other criteria when answering the items. It would seem that the therapist group from Guatemala answers more often with extreme values when doing the Self-test, and the group from Europe provides more moderate responses. The present study may have contributed with a hint to the question made by Stamm (2002): if there are differences (in the Self-test) between people based on culture.

Interestingly, although the therapists in Guatemala had more ST, *hypothesis 2b* could not find any difference in the amount of PTSD-like symptoms or the risk of depression between the countries.

To my surprise, results in hypothesis 2b pointed out that the score for the family of origin was higher in the sample from Guatemala. One could have thought that the general attitude in European families would be one of a more open, then expected for families in Guatemala. But the comparison of the means showed a significant variance

in favour of the families from therapists in Guatemala, which seemed to have a better communication and are more open than their equivalent families in Europe. An explanation could be, that exactly those Guatemalan habitants who had an open and loving family and felt good about the human knowledge this gave to them, chose their profession out of vocation; and not because it could have a monetary reward. It is more possible to gain money in the area of humanistic professions in Europe than it would ever be thinkable in Guatemala. Therapists in Europe may have more than just the vocational motivation when choosing their career.

In the general scheme of things, I would guess that more than a quantitative significance (therapists of one country having more BO and CF than those in another country) the issue here could be more of a qualitative-cultural matter (answering pattern, professional training, family).

Furthermore, one must have in mind that crime is an every day occurrence in Guatemala and that living in an environment of continuous traumatic stress may well increase the vulnerability to ST; this may have contributed as a confusing variable in this study.

Besides the country difference with regard to ST, there was also a country difference in supervision incidence. As testing of hypothesis 2a showed, therapists in Guatemala had less supervision than their colleagues in Europe. A truthful explanation could be that neither financial nor professional training resources for a qualitative good supervision are available in Guatemala.

The importance of supervision for not developing secondary traumatic stress was supported by the acceptance of the *hypothesis 1b*. But this result has to be taken with care because all therapists who did have high ST scores were in Guatemala and we do not know for certain if their high scores are product of secondary traumatic stressors or do rather have cultural causes.

In my opinion, supervision is the best preventive measure against secondary traumatization, for this reason I herewith refer all psychotherapists to take a look at the literature mentioned in the recommendations section.

4.3 Comparison to the student sample

Hypothesis 4a shows that university students have higher rates in intrusion, avoidance and arousal; general feeling state; and in two subscales of disclosure construct. Negative affect and the family of origin score did not reach significance.

The students did have a greater urge to disclose than psychotherapists of this study. At the same time closure was much greater in university students. This can mean that psychotherapists are less closed for their own experiences compared to a specific population, or more exactly, a population that is younger than them and has not heard all the traumatic material they have. These university students were enrolled in the social science department of the Florida State University; in the future they could be psychologists, social workers, doctors, or have another humanistic profession. If these students are candidates to become psychologist themselves one day, we could take this as a hint of the base condition in which the psychotherapists could have been before entering their studies. Although this thought is quite adventuresome, one could carefully dare to say, that with the time (maybe after so much exposure to trauma) there is evidence of a change in direction of lesser closure and also lesser disclosure in therapists working with survivors of violence. This may sound contradictory, but the less closed one person does feel, does not automatically mean that he or she feels the urge or willingness to tell everybody about his or her experience.

Also the PTSD-like symptoms and the general state of feeling were significantly different between students and therapists. Again the students had higher means than did the therapists. Likewise above, therapists had lesser intrusions, avoidance and arousal symptoms, and had also fewer general feelings of being restless. This could be explained by the fact that the therapists learn more about themselves during their education in university and training later on, plus they also learn techniques for how to handle these symptoms. If we additionally take in consideration the results from one paragraph before, it may be fair to say that to some degree during their study time and later professional experience therapists learned to be less closed and also solve distress by themselves (disclose less); so if intrusion, avoidance or arousal symptoms arise, they would know how to handle them.

Later, in *hypothesis 4b* it was not possible to accept the hypothesis that psychotherapists that disclose less have less secondary traumatization. The relevance of this result for the initial assumption that therapists less exposed to trauma material would have less secondary traumatic stress; is that it was not possible to support this theory. But the theory is neither denied, which leaves it open for further investigation.

Hypothesis 4c examined the correlation of the three disclosure constructs with the three PTSD symptoms. Intrusion, closure and negative affect after disclosing, each correlated positively with all other five variables. This is not so surprising if we take into account that closure is a type of avoidance and arousal can be a negative effect of disclosing. The highest correlation was between negative affect and intrusion (r= .629). Besides, intrusion could be understood as a negative affect of disclosure.

Hypothesis 5 tried to clear the assumption of McCann and Pearlman (1990) that 'therapists own unresolved victimizations of early childhood experiences can contribute to the process of VT'. It was not possible to test the hypothesis that therapists with trauma history are more vulnerable to suffer ST than those without a personal trauma history; ironically, because 36 out of the 40 participants of this study, this means 90%, did experience a traumatic event themselves. So it was not possible to divide the group into two for the analysis which could actually be seen as an indication that therapists with trauma history do prevail among these psychotraumatologists.

We will just have to give ourselves satisfied with the results already found in the literature. "Personal trauma history is certainly an important component of STS" (Rudolph, 1997, p. 3), in that study 100% of the participants reported likely Criterion A1 events. Investigation of psychotherapists point out that the treatment of traumatized patients can lead to secondary traumatization, especially to those therapists who have not overcome own experiences of violence (Pearlman & Mac Ian, 1995). But one could also argue that "on the other hand, personal trauma history could be a protective factor because the provider may (…) have had a chance to learn positive coping strategies" (Rudolph, 1997, p. 3).

4.4 Interpretation of the Factor Analysis

The first factor of the factor analysis could be interpreted as follows, the more the therapist experiences what the patient tells in a first person perspective, meaning that he puts himself in the shoes of the patient, imagining to see or feel everything like the patient must had at that time; the more this will lead to more PTSD-like symptoms; general restless feelings; and a feeling that the therapist's own emotions connect to the patients telling. This can be understood as a result of the therapist's willingness to disclose, and therefore promotes the disclosure from the side of the patient. But wanting to disclose also brings closure and negative affection with it. All this strengthen by a lesser probability of taking a step back and undergo the patients' experiences from a spectator (looking from outside), third person perspective.

So, another way of looking at it is, that psychotherapists that can not take a step aside and do rather imagine the patients' experiences in a first person perspective, plus can easily connect to the patients' emotions, and do support disclosure; will experience more PTSD-like symptoms and negative effects of disclosure.

Similar to the study with students from the Florida State University from Elbert and his colleagues (unpublished), one could say for F1 that the greater the number of PTSD-symptoms, the greater was the urge to talk about the event and the belief that this would be beneficial. And at the same time, the fear of negative emotions and closure was greater when more PTSD-like symptoms were present. But also the other direction is plausible; the greater the closure and negative affect, the more exists the urge to talk about the trauma and the more PTSD-like symptoms will this raise.

The factor analysis showed for the second factor that, the more burnout, compassion fatigue and compassion satisfaction the less supervision and years of experience with traumatized patients the therapist will have had; plus lesser experimentation of emotions towards the patient's tellings. Or, conversely, another possible manner would be that if the psychotherapist is young and has no supervision, this will increase burnout, compassion fatigue and satisfaction in him or her.

The factor analysis permits the following interpretation for Factor 3, the more signs of risk for depression or other clinical relevant disorder, the more distressing feelings the therapist may feel, a higher probability subsists that this psychotherapist tries hard not

to think about the stories of his or her patients, and will even more avoid patients with history of trauma.

Causality is not given, but a plausible relation could be that therapists with depression or risk of depression will try to avoid patients with trauma history because they feel more distressed after a session with a traumatized patient; and this only contributes to the therapist's depression feelings. There is an unease feeling engendered by the feelings of distress, and thus a risk of depression.

When doing various factor analysis, just the one with the highest clarification was presented here, I realized that the dimension in which psychotherapists developed burden disruption was not connected to their general work experience neither to the number of traumatized patients treated; this result has also been found by Teegen (2003). Similarly to this study, Steed & Bicknell (2001) did find out that the percentage of client load was independent of the therapists' reports of STS.

To sum up, secondary traumatization seems to be more than just the simply result of an equation from case load per day. Indeed, the number of patients and sessions per week did not make a difference in the TF-SR differentiation nor did it influence the factor analysis or country variable with regard to ST. There is more than just PTSD-like symptoms in the concept of secondary traumatization. Attention has to be paid to specific feelings that the therapist may develop in response to the stories of the patients, which go deep in the therapist's person; here countertransference also plays a role in this matter. To imagine the patient's story from a first or third person perspective is an issue that has been less examined by secondary traumatic stress theorists, but in my opinion plays an important role. And whether this shifting into the patient's position happens in emotions or just images seems also important to me. It is certain that research about ST is still at an early stage and that much further investigation into the subject is required. Nevertheless, the findings of research conducted up to now on the topic, of which this dissertation thesis forms a small part, should prove useful to professionals in the field of mental health care in giving a qualitative better health care service.

4. 5 Limitations and Future Research

There are several limitations to this study. The sample was quite small. Not all the participants who did the interview in Guatemala did make the Professional Quality of Life Self-test. Due to the interesting results found with regard to the country discrepancy it would be interesting to increase the number of subjects in order to back up the significance data here presented.

Due to the recruitment strategy of the sample, it was not possible to assess a response rate. This is a disadvantage as there is no way of knowing whether the response rate for this survey was exceptionally low or high. It is even possible to think that therapists who have much greater secondary traumatization successfully avoided participation.

Because of the design of this study it is not possible to draw causal inferences about the relationship between the variables. It is possible that a number of third variables may have contributed to the findings. One example of a confounding variable could be the fact that the Professional Quality of Life Self-test was in English language and participants in Germany and Guatemala that do not have such a good standard English could have misunderstood some item(s).

Finally, the generalization of these findings are restricted, although the current findings may be particularly relevant to psychotherapists working with victims of organized crime. Plus, if we exclusively consider the German-Swiss sample, it may be especially relevant to therapists treating torture victims.

It would be interesting for further research to retake the concept of trauma-focused versus symptom-relieving and test it in Europe only, more specifically Germany. Perhaps by increasing the number of subjects a level of significance can be achieved.

Another interesting question for future investigation is the attempt to develop and adjust the Professional Quality of Life Self-test in order that no such prevailing difference between countries arises (make it culture-fair), as it happened in this study. There are so few cross-cultural instruments and research in Psychology that it would be an important tool for future cross-cultural studies. Moreover, a more accurate within country differentiation would be welcomed.

5. Recommendations for Preventing Secondary Traumatization

In Guatemala, negative long-term consequences of war and transition lowered the quality of social services, and as a consequence, there is no tradition in supervision. Like seen in other countries, this results in high level of professional stress and burnout, lower enthusiasm, resignation, professional isolation and poorer capacity to work with trauma survivors. Supervision then becomes an important support system with potential to help social workers provide better services for trauma survivors and decrease negative impact of professional stress. Obstacles to introduction of supervision are lack of human and financial resources to train local supervisors and to introduce supervision in social services on a systematic basis (Ajdukovic, 2003).

Professional organizations play an important role in influencing practitioners. They sponsor conferences and publications and establish ethical principles and standards of practice. These organizations are an important part of professional socialization and therefore can significantly increase the quality of mental health services to traumatized people (Figley, 1996).

Lately the literature is full of allusions to the importance of supervision when working with traumatized patients. Moreover, the present study found out that supervision does reduce the risk of ST in general. Therapists who work with trauma survivors need supportive, confidential, professional relationships within which they can process the horrific stories, graphic imagery, and destructive reenactments that are an inevitable part of the work (Pearlman & Saakvitne, 1995). Out of common sense: healthy caregivers are better caregivers! Lansen (1993, p.138) writes that “supervision by an experienced senior staff member, peer group supervision, and monitoring case-load are considered to be important preventive measures”.

It is vital to increase the professional’s awareness of his or her own vulnerability to traumatic recollections, and to train themselves to recognize their own emotional and physical signs of incipient stress reactions. It is necessary to realize that therapy professionals can best help others and continue to do so by recognizing their own personal requirements that make their motivation to help others possible.

Some authors may recommend as a first step to seek out peer consultation. Participating in a peer consultation group is often an invaluable experience. As an

additional step, the therapist could set up a formal supervision arrangement. Finally, personal therapy is an option. Lansen (2002) describes three kinds of supervisions: a) individual supervision, one to one; b) group supervision, a group of therapists working independently get together, e.g. each has his or her own praxis; and c) team supervision, team members that do not work independently. Within the latter, there can be two types of supervision, a case supervision or supervision on the work and interaction of the team. Unfortunately, I will just briefly sketch some ideas about supervision in the next paragraphs. For more detail would blast the frame of this work. I hope the reader will find this information motivating, thus please refer to the respective authors quoted.

To prevent secondary traumatic stress, it is important to pay attention to the therapist's own self-care. In the service of providing high-quality, ethical services and of protecting the therapist and their non-professional lives, it is meaningful that the therapist paces himself in his work as best as he can, therefore to include relaxation and other activities in his off hours that help to leave his work at work. Self-renewal, self-care, and sources of personal pleasure need to be expanded. For instance, to do beautiful things like going to museums, the theatre, art galleries, or buy flowers; all in all, to seek out "non-victim-related activities that provide hope and optimism" (McCann and Pearlman, 1990, p.146). In other words, set aside time to maintain your spirituality; every person will choose to do this in her own different way.

"There is a tremendous sense of personal meaning that evolves from knowing that we are involved in an important social problem by contributing toward ameliorating some of the destructive impact of violence on human lives" (McCann and Pearlman, 1990, p. 147). On the other hand, psychotherapists often don't get feedback about how their helping efforts did or did not make a difference, they do not know about the rest of the healing process. Whereof, the work setting and working style has a profound effect of the therapist's vulnerability to ST. If the therapist prefers being active and working on problem-solving, he or she may prefer short-term work. If the therapist prefers to feel deeply with someone and have time to go through a process together, he or she will be more comfortable in longer-term work (Saakvitne & Pearlman, 1996). A change from impatient to outpatient work, involvement in educational, outreach or research activities may not only be refreshing, it can give a new perspective on patient care.

In any event, do not work alone; use the team for support. This can be difficult in many traditional outpatient care settings. Using the range and diversity of clinical activities in multidisciplinary health care settings can also be a means of mitigating clinical stress. The main thing that organizations and providers can do is to create an atmosphere that supports its staff and colleagues as well as it supports the patients it serves (Rudolph, 1997). A recommendation for organizations working with victims of torture is to hire their stuff on part-time basis. This is the easiest way to prevent burden and secondary traumatization in mental health workers; they will use their time off work productively to "do nice things" and renew their personal energy, because they know the relevance this has on the health care services they provide.

Another point to prevent ST is not to let the guilt shrink or erase your boundaries, e.g. "others are so bad that my little boundaries are not so important". Boundaries are important! It is necessary to have enough sense to say "it is too much, I will take off". Therapists should make sure to know *when* to go and see pleasant things. "Therapists who are able to enjoy a long career generally free of STSD, recognize the importance of setting realistic goals, limits and boundaries in their work" (Figley, 1996, p.576).

A recent repairing measure by Gentry, Baranowsky & Dunning (2002) called the Accelerated Recovery Program for Compassion Fatigue (ARP), proposes strategies for addressing and resolving the distress resulting from exposure to trauma experienced directly by another. ARP combines several brief trauma protocols, a comprehensive assessment package, and a self-administered self-care plan. These treatment/training strategies promise to provide an effective means to alleviate CF symptoms and reinforce resiliency.

Furthermore, it is important to be aware of the conflict areas or unresolved traumas that are reactivated by the therapeutic process (McCann and Pearlman, 1990). The good thing is that nowadays institutions and colleagues are beginning to recognize that these findings are real, and not a shameful or disgraceful phenomena. Therapists can talk about their secondary traumatic stress reactions and see them as an enrichment of the therapeutic process if they can be identified, understood and personally assimilated.

These measures cost a lot of time and money. For the Management, Associations and sponsors it is important to discern that the effort is worth it, since it has a positive repercussion on the quality of the job. Furthermore, it is important to establish a

treatment team with carefulness. The personal stability of the workers is, together with their professional qualifications and working experience, very important. The team also has to have a “containing” function in itself and should be a supporting environment. (Lansen, 1996).

Ultimately, the most effective remedy for STS is the breadth and depth of the therapist’s network of supportive relationships, combined with the setting of approximate limits. One can never overestimate the importance of the therapist’s family in giving support. It is critical however to draw a clear boundary between work and home and even more important to have a clear understanding with one’s family about the traumatic nature of psychotherapy (Figley, 1996).

You need professional commitment both to recognize that you are traumatized and to take effective action. It is important to realize that life can be unfair and ugly at times; and that patients with real and important therapy needs have existed, exist now, and will exist long after the therapist has retired.

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7. Appendix

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People who have witnessed or experienced atrocities and life threatening events are often deeply affected by these experiences. In this study for my graduation thesis I want to find out about the load, pressure and mental tension that mental health professionals are exposed to. Does this represent a condition that most psychotherapists in Guatemala, Switzerland and Germany suffer from? How can we best help affected mental health workers? These are some questions that you can help us clarify.

As part of your work, you may have had the opportunity to interact with survivors of domestic violence, different forms of abuse, human rights violations, and other traumatic events. In order to determine adequate care and prevention methods for those who work with such traumatized clients/patients, we are interested in studying your experiences both related and unrelated to your work.

In this interview, we would like you to respond to a variety of questions; some may be related to your experiences, others may not be. Your answers will be compared to those given by a comparable population in both: Guatemala and Germany/Switzerland. All of your responses will be strictly confidential.

We realize that in some parts of the interview you might recognize the criteria for PTSD (post-traumatic stress disorder). We are not looking into that direction, but would like to obtain a picture of Compassion Fatigue (Figley[1]), Vicarious Traumatization (McCann[2] & Pearlman[3]), also known as secondary traumatization. Since so many studies about this phenomenon exist, we can not deny its relevance in the professionals' daily work. With your help we are hoping to contribute to this research area, therefore we ask you to answer the items as sincerely and accurately as possible.

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We greatly appreciate you taking the time to complete this interview!

1. _____Your age 2. _____Male _____ Female

3. What is your profession? Describe your educational background?

_____ _____

4. For how long have you been working in your professional field?

_____ years in practice, and ____ years of experience with traumatized patients.

5. What kind of therapy do you use? (20:80) please, give a relation

_____ symptom-relieving (concentrating on daily-life problems, no immersion in cause, supportive)

_____ trauma-focused (concentrating on the traumatic event of the target person)

6. When you do psychotherapy, what theoretical approach do you engage mostly in work? (0 never – 4 always)

____ cognitive-behavioral ____ systemic therapy ____ pharmacotherapy

____ psychoanalysis ____ counseling ____ art-therapy

____ rational-emotive ____ specify other:

7. How many therapy-hours do you usually plan for the treatment of a traumatized patient? ____ hours.

8. In the last year: how many people that lived through a traumatic event have you treated /taken care of? ____ persons.

9. How do you feel after a therapy session or verbal interaction with a traumatized person?

Amount of distress (angustia, ansiedad): 0 no distress ___ 1 ___ 2___ 3___ 4 a lot

___ sadness ___ anger ___ frustration ___ relieve ___ achievement

___ compassion ___ anxiety ___ sorrow

10. When you feel overwhelmed/loaded, which of the following describes your way of coping?

___ keep everything for yourself ___ try to speak to other people about something else

___ try to speak to other people about your feelings and issues directly related to the bothering topic.

Please indicate how you generally feel:

0	**1**	**2**	**3**
Almost never	**Sometimes**	**Often**	**Almost always**

11. _____ Do you feel nervous and restless.
12. _____ You worry too much over something that really does not matter.
13. _____ Do you have disturbing thoughts.
14. _____ Some unimportant thought runs through your mind and bothers you.
15. _____ You take disappointments very seriously and can not take them out of your mind.
16. _____ You get in a state of tension or turmoil as you think over your recent concerns and interests.

Please decide how much the symptoms bothered or distressed you in the last month, including today.

0	**1**	**2**	**3**
Not at all	**A little**	**Quite a bit**	**Extremely**

17. _____ Feel low in energy, slowed down
18. _____ Blame yourself for things
19. _____ Cry easily
20. _____ Lose of sexual interest or pleasure
21. _____ Have poor appetite
22. _____ Have difficulty falling asleep, staying asleep, or waking up early
23. _____ Feel hopeless about the future
24. _____ Feel blue
25. _____ Feel lonely
26. _____ Have thoughts of ending your life
27. _____ Have feelings of being trapped or caught
28. _____ Worry too much about things
29. _____ Feel no interest in things
30. _____ Feel everything takes a great deal of effort
31. _____ Feel worthless
32. _____ Yes ____No These feelings haven not occurred during the last month, but you have experienced them earlier in your life.
33. _____ Yes ____No After an intense session with a traumatized patient it is more likely that you experience these feelings.

Use this scale to answer the following questions:

0 Strongly disagree that it describes my family of origin.
1 Disagree that it describes my family of origin.
2 Neutral
3 Agree that it describes my family of origin.
4 Strongly agree that it describes my family of origin.

34. _____ Your parents encouraged family members to listen to one another.
35. _____ In your family, you felt that you could talk things out and settle conflicts.
36. _____ Found it difficult to express your opinions in your family.
37. _____ Found it easy in your family to express what you thought and how you felt.
38. _____ Remember your family as being warm and supportive.

Many people have lived trough or witnessed very stressful and traumatic events at some point in their lives. I will read to you some events that may have happened to **you**.

39 □ Serious accident, fire, or explosion (for example an industrial, farm, car, plane, or boating accident)
40 □ Natural disaster (for example, tornado, hurricane, flood, or major earthquake)
41 □ Non-sexual assault by a family member or someone you know (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)
42 □ Non-sexual assault by a stranger (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)
43 □ Sexual assault by a family member or someone you know (for example, rape, or attemted rape)
44 □ Sexual assault by a stranger (for example, rape, or attemted rape)
45 □ Military combat, war zone or migration
46 □ Sexual contact when you were younger than 18 with someone who was 5 or more years older than you (for example, contact with genitals, breasts)
47 □ Imprisonment (for example, prison inmate, prisoner of war, hostage, kidnapping)
48 □ Torture
49 □ Life-threatening illness
50 □ Other traumatic event:

51 If you marked more than one traumatic event above, please specify which event bothers you *the most*. (If only one traumatic event was marked, mark the same one below.)

- ☐ Accident
- ☐ Disaster
- ☐ Non-sexual assault/someone you know
- ☐ Non-sexual assault/stranger
- ☐ Sexual assault/someone you know
- ☐ Sexual assault/stranger
- ☐ Combat/migration
- ☐ Sexual contact under 18 with someone 5 or more years older
- ☐ Adoption or fostercare
- ☐ Imprisonment
- ☐ Torture
- ☐ Life-threatening illness
- ☐ Other

In the box below, briefly describe the traumatic event you marked above.

(Below are several questions about the most traumatic event you have just described above.)

52 How long ago did the traumatic event happen? (circle ONE)

[1] Less than one month
[2] 1 to 3 months
[3] 3 to 6 months
[4] 6 months to 3 years
[5] 3 to 5 years
[6] More than 6 years

(For the following questions, circle Y for Yes or N for No)

During the traumatic event:

53 [Y] Were you physically injured ?
[N]

54 [Y] Was someone else physically injured ?
[N]

55 [Y] Did you think that your life was in danger ?
[N]

56 [Y] Did you think that someone else's life was in danger?
[N]

57 [Y] Did you feel helpless ?
[N]

58 [Y] Did you feel terrified ?
[N]

*Below is a list of problems that people sometimes have after experiencing traumatic events. Using **the traumatic event, that still bothers you the most**, please indicate how often this feeling has happened to you **in the past month,** using the following scale:*

0: Not at all, or only once
1: Once in a while (i.e., once a week)
2: Half the time (i.e., 2 to 4 times per week)
3: Almost always (i.e., 5 or more times per week)

59. _____ Having upsetting thoughts or images about the event that come into your head when you don not want them to.
60. _____ Having bad dreams or nightmares about the event.
61. _____ Reliving the event, that is, acting or feeling as if it was happening again.
62. _____ Feeling emotionally upset when you were reminded of the event (for example, feeling scared, angry, sad, guilty, etc.).
63. _____ Experiencing physical reactions when you were reminded of the event (for example, breaking out in a sweat, heart beating fast).
64. _____ Trying not to think about, talk about or have feelings about the event.
65. _____ Trying to avoid activities, people, or places that remind you of the event.
66. _____ Not being able to remember an important part of the event.
67. _____ Having much less interest or participating much less often in important activities.
68. _____ Feeling distant or cut off from people around you.
69. _____ Feeling emotionally numb (e.g., being unable to cry or unable to have any feelings)
70. _____ Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life).
71. _____ Having trouble falling or staying asleep.
72. _____ Feeling irritable or having fits of anger.
73. _____ Having trouble concentrating (for example, drifting in and out of conversations, losing track of a story on television, forgetting what you read).
74. _____ Being overly alert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.).
75. _____ Being jumpy or easily startled (for example, if someone walks up behind you).

76. How long have experienced the problemsthat you indicated above? (check one):
    _____ Less than 1 month
    _____ 1 – 2 months
    _____ 3 or more months

77. You had these problems at one point, but now they have gone away: __ agree __ disagree.

Use the following scale to answer the next set of items:

0	**1**	**2**	**3**	**4**	**5**
Strongly disagree					**Strongly agree**

78. _____ You never find the right time to talk about the experiences that you had during the event.
79. _____ Talking about the event makes you feel very sad.
80. _____ You like to talk about the event as often as possible.
81. _____ Talking about the event is distressing.
82. _____ You often think about the event, but never talk about it.
83. _____ You often feel the urge to talk about your experience.
84. _____ The more often you talk about the event, the clearer the picture gets that you have of the event.
85. _____ It is important for you to repeatedly talk about what and how it happened.
86. _____ You find it difficult or even impossible to talk with someone else about the event.
87. _____ You are extremely tense when you report the event.
88. _____ You haven't told anybody about the experience.
89. _____ When describing what happened, you feel shaky, nervous, and tense.

The following questions are about whether the symptoms you just rated have interfered with any of the following areas of your life ***during the past month.***

Have these symptoms caused you serious problems in your…

90.	Work?	_____Yes	_____No	_____ Not applicable
91.	Household chores?	_____Yes	_____No	_____ Not applicable
92.	Relationship with friends?	_____Yes	_____No	_____ Not applicable
93.	Fun and leisure activities?	_____Yes	_____No	_____ Not applicable
94.	Relationship with family?	_____Yes	_____No	_____ Not applicable
95.	General satisfaction with life?	_____Yes	_____No	_____ Not applicable
96.	Overall function in life?	_____Yes	_____No	_____ Not applicable

*Use the following scale to indicate what you typically think is **important in your work**:*

0	**1**	**2**	**3**	**4**	**5**
Strongly disagree					**Strongly agree**

97. _____ The primary goal of diagnostic interviewing is to gain useful information from the eyewitness.
98. _____ The interviewer should have a neutral position.
99. _____ The therapist must be empathic with the person.
100. _____ The interviewer should not be intrusive and should not try to ask a person to give testimony if s/he does not want to.
101. _____ Giving testimony brings always at least some relief to the eyewitness.
102. _____ At some point during the interview the patient often gets stuck or their reports begin to be incomplete/fragmented.
103. _____ It would be useful for interviewers to know about the psychological consequences of trauma and extreme stress.
104. _____ After completing a therapeutic session you typically feel calm and pleased.
105. _____ Sometimes during an interview, you are not sure how to help the person to get through it without disturbing him/her even more.
106. _____ When you encounter a traumatized survivor, you are not certain whether they fit clinical criteria for disorders related to stress and other than PTSD
107. _____ Interviewing eyewitnesses often tends to upset them emotionally.

108. Please estimate how many of the problems that your traumatized patients have, derivate or are by-products from traumatic events:

____ all ____ some of them

____ most of them ____ none.

109. How many psychological interviews or pychotherapy did you undertake with eye-witnesses /survivors of severe traumatic events:

____ never ___ about 2-9 times ___ 25-50 times.

____ once ___ about 10-25 times ___ more than 50 times.

110. Do you have contact/interaction with eyewitnesses /survivors of severe traumatic events outside your worksetting?:

____ yes how often or what type of interaction:

____ no

111. Do you think that (check one):

_____ you can depend on your friends to be there when you need them

_____ trusting other people is generally not very smart.

112. How many sessions /meetings with traumatized people do you have in a week? ___sessions.

113. Do you feel confident about your ability to make decisions/ judgment? yes ___ no ___.

114. At the time being, estimate how many patients you have in total (_____). What is the number of those who have lived a traumatic event? _____ persons.

115. How much time (in percentage) during a complete therapy/treatment, do you really talk about the **traumatic event itself** with the victim (as compared to other problems or symptoms)?

____ %.

116. Do you have any kind of supervision, Mediation (Teamgespräch), Intergroup-debate/negotiation, training in dealing with traumatized patients?

___ supervision ___ coaching (dyad) ___ mediation (>2, in a group)

___seminar ___ training ___ other:

117. How is you social network? Do you meet people often after work? ___ yes ___ no.

118. With whom do you spend your free time?

119. What is the topic of most stories you hear about? (make a hierarchy beginning with 1 for the most often)

- □ Accident
- □ Disaster
- □ Non-sexual assault/someone you know
- □ Non-sexual assault/stranger
- □ Sexual assault/someone you know
- □ Sexual assault/stranger
- □ Combat
- □ Sexual contact under 18 with someone 5 or more years older
- □ Imprisonment
- □ Torture
- □ Life-threatening illness □ Other:

II. NOW JUST THINK ABOUT WHAT YOUR PATIENTS TELL YOU ABOUT **THEIR** TRAUMATIC EVENT:

1. How many times in the last 4 weeks have you thought about the stories your traumatized patients have told you? ____ times.

2. Have you experienced intense feelings about these stories?
   ___ yes describe:
   ___ no

3. Have you felt that these have created obstacles in you private life (with partner, children, etc.)?
   ___ yes of what kind:
   ___ no

4. How do you experience what your patient tells you?
   ___ in images ___ just emotions (empathize with emotions of patient)
   ___ 1st person experience ___ 3rd person exp.

5. How hard do you try NOT to think about your patients' stories?
   ___ very hard ___ not so hard ___ not at all.

6. In the last 4 weeks did you have physical reactions about your patients' stories? (e.g. suddenly recall a frightening experience and feel your heart beating faster, or breaking out in a sweat)
   ___ a lot ___ not so much ___not at all.

7. Do you try to avoid the places your patients talk about, even though you know those places are not really dangerous for you? ___ yes ___ sometimes __ no

8. Do you try to avoid the patients with history of trauma? ___ yes ___ sometimes __ no.

9. Do you feel internally distant from a traumatized patient? ___ yes ___ sometimes __ no.

10. Do some of your own emotions become related or connected to what the patient told you in therapy? ___ yes ___ sometimes __ no.

11. How do you feel after this interview?
    ___ bothered ___ anxious/restless ___ relieved/calm ___ reliving some event.